

Police practice in cases of Sudden and Unexpected Child Death in England and Wales. An Investigative Deficit?

John Fox, University of Portsmouth

Abstract

The investigation of Sudden Unexpected Child Death is complex because whilst most children who die suddenly do so because of natural causes, it is sometimes difficult to detect when a child has, in fact, been unlawfully killed. The system in England and Wales involves a joint agency response to child death and for various reasons the police contribution to that investigation is sometimes inadequate. The arguments presented in the paper are made on the basis of empirically derived findings, drawing from original research based upon qualitative interviews with nine senior detectives working in the areas of child abuse or major crime, as well as focus groups of senior detectives, and a limited contribution from pathologists. This paper explores whether there is an investigative deficit in respect of potential child homicide when compared to an adult domestic homicide and it concludes that in some areas the most vulnerable people in society may be at risk because of issues such as inadequate training, inflexible force policies, and under-resourced police investigation of child death. The findings reveal important implications for police investigative training and a clear and significant deficit in the investigative resources available to the lead investigator on a child death investigation which may or may not be a homicide, compared with the resources available to the senior investigating officer on a straightforward domestic homicide when the victim is an adult.

Introduction and background

The majority of children who die do so from natural causes, and the disease, genetic condition, or ailment is often easily and quickly identified. However, there are approximately 230 deaths of babies and toddlers every year in

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3 the UK which despite an investigation, remain unexplained (Lullaby Trust,
4 2015). In respect of an infant (a child under 1 year of age), the
5 phenomenon known as SIDS is probably the cause of death in most cases
6 of unexpected death. This notion is supported by Kennedy (2004, 2016).
7 However, SIDS is not a diagnosis; it is a label perhaps designed to remove
8 a stigma or feeling of lifelong guilt from bereaved parents. This
9 phenomenon is not understood at all well, and no-one actually knows the
10 mechanism which occurs to cause death (Emery, 1989) although
11 suggestions such as the 'Triple Risk Hypothesis' (Guntheroth & Spiers,
12 2002) – i.e. an infant whose physiological development is slightly behind,
13 who has a minor ailment such as a small infection, and who lives in a sub-
14 optimal environment such as a house where people smoke - attempt to
15 explain what may cause an infant to die. Suggestions such as these are no
16 more than a 'best guess' at what may have happened, and in the absence
17 of identifying a conclusive natural cause of death the possibility that the
18 child has been deliberately killed remains plausible as an explanation.
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33 It is widely accepted that within the number of cases which over the years
34 have been classified as Sudden Infant Death Syndrome (SIDS), Sudden
35 Unexpected Death in Childhood (SUDC), or Cot Death, a hidden proportion
36 is in fact the result of maltreatment or deliberate harm (e.g. Emery, 1993;
37 Levene and Bacon, 2004; Fox, 2007). These cases of homicide may remain
38 undetected for reasons which could include a failure of the 'joint agency
39 response' (HMG, 2018). In other words, there is a failure either by
40 Paediatricians or Pathologists to observe subtle physical signs that a child
41 has suffered maltreatment or a failure by Police investigators to carry out
42 a thorough and searching investigation on behalf of the Coroner.
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52 Estimates of the proportion of SIDS registered cases which are in fact
53 undetected homicides vary considerably, although some authors suggest
54 up to 10% - 20% may be frank homicide, with maltreatment (abuse or
55 neglect) being a contributory, though not necessarily a causal, factor in a
56 similar proportion (e.g. Emery, 1993; Fleming et al., 2000; Levene and
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3 Bacon, 2004; Sidebotham et al., 2005). For policing purposes, it does not
4 really matter what the proportion is, but rather it should be considered
5 unacceptable for there to be *any* deliberate killing of a human being which
6 does not attract a full and professional investigation.
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11 Marshall (2012) estimates that there are probably between 69 and 84 child
12 homicides in England and Wales each year. The reason the number is rather
13 vague is that as discussed above, within the number of known deaths which
14 end up being classified as SIDS or Unascertained there is an unknown
15 number of 'covert homicides' (Vaughan and Kautt, 2009) which are never
16 identified as crime. Because they cannot defend themselves it is accepted
17 that it may be possible to kill a small child and leave no physical trace of
18 an assault. This is supported by Truman and Ayoub (2002) who suggest
19 that deliberate suffocation of a baby rarely leaves any physical signs,
20 making it impossible to differentiate from SIDS on clinical grounds alone.
21 In some cases it is understandable that even the most thorough and
22 professional investigation by a police officer, paediatrician and pathologist
23 might fail to identify that crime has occurred. There are likely to be other
24 cases however where stones are left unturned and clues not found because
25 of a lack of police resourcing or a lack of expertise by the investigating
26 officer.
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41 In respect of children over the age of 1 year the label known as SIDS cannot
42 be used to explain the death, and if the joint agency investigation
43 subsequently fails to identify the cause, such a case would usually be
44 classified as "Unascertained". In respect of children over one year of age
45 and the consequent absence of SIDS being a possibility, the failure to
46 recognise an undetected homicide is more likely to be as a result of an
47 inadequacy in the police contribution to the joint agency investigation. This
48 is because the detection of a disease or genetic condition is a scientific
49 process with certainty as an end result, whereas the police investigation of
50 a potential homicide is, in large part, an art and its success is dependent
51 on the decision making of the Lead Investigator, the adequacy of their
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3 training, and the staff resources available to him or her, because these
4 factors all dictate the amount of activity conducted to uncover any possible
5 clues as to the cause of death.
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9 This paper will identify and explore some of the factors which tend to make
10 the successful discovery and subsequent investigation of child homicide
11 problematic. The consequences of a failure by police to identify when a child
12 has been unlawfully killed is of great consequence, not just in providing
13 some posthumous justice for the deceased but, and perhaps more
14 importantly, in ensuring the protection of any living siblings or those yet to
15 be born.
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22 **Method**

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25 The paper has been informed by an original research study carried out by
26 the Author between March and July 2019 seeking to explore the question,
27 *"Is there an investigative deficit in respect of SUDC which could mean that*
28 *the likelihood of the death of a child which is in fact homicide, but not*
29 *recognised at that point, is less likely to be identified as such compared to*
30 *an adult?"*. The conclusions draw on data gathered using qualitative
31 research methodology including interview and focus group data. Fielding
32 (2000) indicates that much police research is rooted in this method, and it
33 may be considered that, given one is likely to be interviewing confident,
34 professional people, this made it the most appropriate method of gathering
35 data.
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46 The research was designed to include participants with a range of different
47 perspectives on SUDC investigation, specifically senior detectives from the
48 Major Crime and Child Abuse Investigation disciplines, and a small number
49 of Home Office registered Forensic and Paediatric Pathologists. The
50 respondents were therefore chosen carefully for their knowledge and
51 expertise in the subject, and the likelihood that they would represent
52 different standpoints on the issues in question. The sample represents what
53 Patton (2001) calls a 'purposeful sample'.
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3 Detailed qualitative face to face interviews were conducted with a sample
4 of 4 current Major Crime SIOs from two different police areas, and 5 Senior
5 Detectives from Child Abuse Investigation Units working in four different
6 Force areas. These interviews were recorded and fully transcribed. The
7 transcripts were loaded into NVivo 12 CAQDAS software which assisted with
8 coding and analysis of the interviews using adapted Grounded Theory
9 (Glaser and Strauss, 1967). The adapted version of Grounded Theory
10 employed followed the position taken by Strauss (1990); consistent with
11 other adapted versions of Grounded Theory, the application primarily
12 focussed on the coding and preliminary validation stages, as these were
13 judged most appropriate to the data available.

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16 A survey was emailed to 6 pathologists represented by 2 Specialist
17 Paediatric Pathologists and 4 Forensic Pathologists, all of whom have been
18 involved in child death cases. The questionnaires were tightly focused on
19 the research question, 3 Forensic Pathologists agreed to take part in the
20 study and their responses were included within the package of data loaded
21 into NVivo and coded and analysed alongside the other material.

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24 Finally, to explore and test one of the key issues which had emerged during
25 early interviews, two focus groups each consisting of 5 senior detectives,
26 with a mix from the Major Crime Teams and Child Abuse Investigation
27 Teams in two separate police force areas, were given a case description
28 relating to a straightforward child homicide investigation, and the groups
29 were asked to discuss and estimate the resourcing levels which would be
30 allocated to the case and the activity which would be generated. The results
31 were compiled on flipcharts and the data, together with commentary, is
32 provided in a table below.

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35 The limitations of the design are such that although a total of 22
36 participants provided data for analysis, from a policing perspective they
37 were limited to four force areas (out of the 43 forces in England and Wales),
38 and arguably each individual element of the sample is itself not large.

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3 It is recognised (Bryman, 2004) that *qualitative* researchers have a
4 particular responsibility to ensure they fairly and accurately reach their
5 conclusions, so as to guard against the possibility that an ill thought out,
6 non-representative anecdote from a respondent might adversely influence
7 an inference or conclusion. The mixed, cross discipline design of the
8 research enabled the Researcher to test and validate comments being
9 made about the key issues. However the limitations of a qualitative
10 research design are also recognised, and while the findings are suggestive
11 and allow us to identify some important dimensions of the research
12 questions and hypotheses, the analysis cannot be definitive or conclusive.
13 It is noted that a qualitative approach is often adopted in pioneering,
14 exploratory research and it is intended that this paper provides a
15 *contribution* to an evaluation of the current state of SUDC investigation in
16 England and Wales, and further research is suggested in the conclusion.
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Position	Role	Number
Detective chief inspector	MCT	2
Detective inspector	MCT	2
Detective inspector	CAIU	8
Detective sergeant	CAIU	7
Forensic Home Office Pathologist	n/a	3
Total respondents		22

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42 **Figure 1. Breakdown of Respondents Sampled**

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45 The research reported in this paper was conducted in accordance with the
46 advice contained in the British Society of Criminology Statement of Ethics
47 (2015).
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49 50 **Findings and Discussion**

51 52 ***The effect of police budget cuts on major crime investigation***

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55 Much of the recent discourse in policing is dominated by a perception that
56 the quality of police work, and in the context of this paper, the quality of
57 investigation have been affected by public sector budget cuts. It might be
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3 useful to briefly explore whether this is the case, and if so, how it might be
4 affecting homicide investigation and in particular the investigation of child
5 homicide.
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9 It is confirmed by Brogden and Ellison (2013) that since 2010 the Police
10 Service in England and Wales has suffered severe budget cuts and that a
11 dramatic reduction in policing services has occurred. A recent study by
12 Hargreaves (et al, 2018) reveals that there was a reduction of 21,000 police
13 officers between 2010 and 2018, bringing overall Police Service numbers
14 down to 122,404. The evidence that since 2010 the Police have had to
15 mitigate against Government funding cuts is therefore incontrovertible, and
16 since for all Police Forces the staff salary portion of their overall budget is
17 around 80% (e.g. PCC Hampshire, 2017) it has been inevitable that to
18 achieve necessary savings officer numbers have been reduced to well under
19 their authorised maximum establishments. Evidence outlined below
20 indicates that the Major Crime Teams (MCT) created in many police forces
21 to primarily deal with homicide cases, have not been protected from staff
22 reductions.
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35 Although due to their partisanship it is often unhelpful to cite politicians in
36 an academic paper, in June 2019 it was reported in The Guardian (a UK
37 National Newspaper) that in 2019 Freedom of Information requests to all
38 43 UK police forces were made by the Labour Party Policing Spokesperson.
39 This survey claimed to reveal that “the number of detectives in major crime
40 and murder squads has been cut by 28%” (Dodd, 2019). This figure is
41 broadly supported by the respondents in the present study.
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49 All MCT participants (n = 4) confirmed that their teams had been subject
50 to significant reductions in investigator numbers over the last few years.
51 Specific utterances include:
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55 *“There has been a huge impact on our resources and it is getting very*
56 *difficult now to properly investigate the cases we get. Every homicide*
57 *we deal with is under-resourced.” (MC 5)*
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3 *"There has been a huge reduction in resources in major crime teams*
4 *even in the last 15 months we've significantly reduced again. We*
5 *skimmed right back so you have not only got low numbers in terms of*
6 *people, we also go often in collaboration and a lot of that continuous*
7 *push –pull between the teams and the different SIOs over a very small*
8 *pot of people to do the work. There were 5 DCIs- that's gone down to*
9 *4. And there were 5 DIs that's gone down to 4. So we've lost a DCI*
10 *and a DI from each crime. In respect of detective constables, in [my*
11 *force] we went from 18 DCs down to 12."* (MC1)
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20 It could perhaps be argued that officers such as these, who are competing
21 with other parts of their force for resources, are hardly likely to paint a
22 healthy picture of their staffing levels, but one of the MCT Respondents
23 actually did provide the Researcher with a picture – photographic evidence
24 – to illustrate the reduction in his MCT over the past 10 years.
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30 *"Undoubtedly [there have been staff reductions]. Recently I arranged*
31 *for the major crime team across the force to have a team photograph*
32 *after a CPD day. And one of the reasons I did that, other than it's a*
33 *nice thing to do, was to emphasise the point that our numbers have*
34 *greatly reduced since the last time the team had a team photograph.*
35 *So we have both of those photographs [shown to the Researcher] and*
36 *it's difficult to put a number on it off top of my head, but I would say*
37 *that we are probably somewhere in the region of a third to 50 percent*
38 *less staff now that what we were 10 years ago."* (MC3)
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47 It was fortuitous that one MCT Respondent had, before they joined the MCT
48 been part of the 'Change Programme' Team which had to decide where
49 staffing cuts in the force would fall. When asked whether police budget cuts
50 had any effect on major crime teams, this Respondent made an illuminating
51 comment from that other perspective:
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57 *"Yes, sure. I've only been on major crime since [5 months ago]*
58 *although I spent 2 years on what was called the Specialist Crime*
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3 *Capabilities Programme which is basically a budget cutting change*
4 *programme for specialist crime which includes major crime, where we*
5 *had to make 20 percent savings across the whole specialist crime*
6 *including major crime. It did not have to be 20 percent from each*
7 *discipline, it had to be 20 percent across the board. So that was*
8 *relatively recent so obviously there were cuts within major crime and*
9 *changes to processes and roles as a part of that process in order to*
10 *save money and improve efficiency” (MC 2)*
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18 Having therefore obtained supporting evidence that the report in the
19 Guardian newspaper (Dodd, 2019) is likely to be accurate, it was important
20 to explore whether the workload of the teams had reduced in line with their
21 staffing reductions. As a follow up question to all MCT Respondents they
22 were asked whether there were fewer murders or serious crimes to deal
23 with now, but all claimed that their core workload had not reduced, and in
24 fact one respondent remarked:
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31 *“No, it’s gone the other way. It’s gone up, particularly in the last 2 to*
32 *3 years, there has been a significant increase in work.” (MC3)*
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36 The present study was designed to establish whether the investigation of
37 childhood death, and in particular the chances of successfully establishing
38 whether such a death is in fact homicide, may be adversely affected by
39 these changes in the staffing levels of MCTs. Although none of the MCT
40 Respondents indicated that their team would not normally deal with cases
41 of child death *which had clearly been identified as homicide from the outset,*
42 as discussed earlier it is often very difficult to make that early
43 determination. It is accepted that even with clearly identified adult
44 homicides many are 'self-solvers' as described by Martin Innes (2003), so
45 not a lot of detective work is required in their investigation. However, it is
46 argued in this paper that due partly to complex pathology and controversy
47 over medical evidence, as well as the fact that the child victim is often cared
48 for by the perpetrators, meaning less reliance can be placed upon trace
49 forensic evidence, child murders are rarely 'self-solvers' and do need a lot
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3 of detective work and multi-agency cooperation to solve. The next part of
4 the discussion will explore whether there is a disparity, or deficit, in respect
5 of resourcing and training for those investigating a sudden unexpected child
6 death when compared with those officers investigating the suspicious death
7 of an adult.
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12 ***Resourcing and training for child death investigation***

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15 One of the peculiarities with child homicide is that even if a police force has
16 a dedicated Major Crime Team, as will be discussed later, there is
17 sometimes ambiguity as to whether *they* will actually investigate this sort
18 of crime, or whether it will be investigated by officers from the Child Abuse
19 Investigation Units (CAIU). What is probably universal is that until a sudden
20 unexpected child death has been identified as suspicious, it is extremely
21 unlikely that a Major Crime Team would become involved at all, so the early
22 lines of enquiry to determine whether or not there are suspicions will
23 normally be carried out by a small group of CAIU officers often led by a
24 Detective Inspector or a Detective Sergeant who may well not have any
25 standardised training in homicide investigation. In the present study it was
26 reported by Respondents from the CAIUs that the typical resourcing for a
27 SUDC would be a small team perhaps consisting of a Detective Inspector
28 and 2 or 3 investigators. When asked if they were the Lead Investigator on
29 a regular SUDC case and how many staff they were likely to have on their
30 investigation team, these responses were representative of that group:
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45 *"On the day, a DI and a DS. Possibly with access to a couple of*
46 *investigators"* (CA3)

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49 *"Definitely two, with a Detective Sergeant accompanying myself.*
50 *Additional staff could possibly be made available if necessary."* (CA5)

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54 *"Resource wise I am probably going to say DI, DS and 5 DCs. If it was*
55 *a late night one, or a weekend, there would be fewer people involved."*
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3 It was then interesting to contrast these numbers with the MCT
4 Respondents who were asked how many staff they would deploy if the case
5 was a straightforward domestic homicide where the victim was an adult –
6 for example, a husband kills his wife within their home. Even on such a
7 classic 'self-solver' (Innes, 2003), the MCT Respondents claimed they were
8 likely to work with a team of around 12-20 detectives at their disposal.
9 These responses are representative of that group:

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16 *"I'll be expecting, to include my specialist leads as well, so crime scene*
17 *managers, CSIs etc. So I'll be looking at 12 to 14."* (MC1)

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21 *"I would have 4 DSs and 20 investigators - DCs and IOs. It will be*
22 *anyone who is working. If it is a new job, everyone who is working."*
23 (MC2)

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27 And a respondent who had been called out to exactly such a case a few
28 days beforehand recalled:

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31 *"I would say we had about something in the region of 20 investigative*
32 *officers in total to deal with what was a fairly contained job."* (MC3)

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35 Interestingly, this latter Respondent had previously worked as a Detective
36 Inspector on a CAIU and claimed to have investigated 26 SUDC cases. The
37 Respondent MC3 confirmed that typically in those cases the 'team' would
38 have just consisted of themselves plus 1 Detective Sergeant.

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43 It is important at this point to note that of the two types of cases described,
44 the adult case is identified as a homicide, whereas the child case is still to
45 be determined as either natural death or a suspicious death. It could be
46 argued therefore that the study is comparing apples with pears. In one
47 sense a SUDC is 'just another' type of sudden death investigation however,
48 the position taken in this paper is that the sudden and unexpected death
49 of a child should never be considered as a routine event. The police have
50 traditionally attended any case of sudden death resulting from an unknown
51 cause, and their duties can include the verification of death and the
52 submission of a report to the Coroner (Fox, 2007). Usually a single
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2 uniformed police officer would attend the report of a sudden death of
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4 an elderly person and they make only basic enquiries to check if any
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6 crime may have occurred. There would usually be no involvement by a
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8 specialist investigator because elderly people die as a matter of course
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10 and sudden death cases are a common occurrence. However, as
11
12 discussed above, unexpected childhood death is relatively rare in
13
14 England and Wales, and they should never be considered by the
15
16 police as routine natural and inevitable events. Indeed, the College of
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18 Policing guidance on this subject is clear that "*Healthy children are not*
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20 *meant to die, and when they do these children deserve the right to have*
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22 *the death fully investigated in order that a cause of death can be*
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24 *identified , and homicide excluded*" (ACPO, 2014, p.5).

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26 It is clear from the empirical evidence in the current study that the police
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28 in England and Wales do not treat SUDC cases as 'routine' sudden deaths,
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30 and all Respondents confirmed that a Detective Inspector, rather than a
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32 uniformed constable, would investigate SUDC in their area. An
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34 important step was taken by ACPO (now the National Police Chiefs
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36 Council) to encourage Chief Constables to ensure that SUDC was
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38 resourced with at least a minimum number of investigators. The College
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40 of Policing Guidance (ACPO, 2014, p.13) suggests, "*The thorough*
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42 *investigation of an unexpected child death cannot be carried out by a*
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44 *single investigator. Even when there are no apparent suspicions, as a*
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46 *minimum it is suggested that a team of three investigators will be required*
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48 *to assess and manage scenes, carry out interviews and follow lines of*
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50 *enquiry*". This guidance perhaps helps to ensure that the sudden death
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52 of a child is investigated far more thoroughly than would be the case if
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54 the deceased was an elderly adult, and broadly this current research
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56 indicates that the sort of investigator resourcing expected in the
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58 guidance is being adhered to. However, an important thrust of the
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60 present paper is to contribute to a discussion as to whether, despite
recent improvements, more could or should be done to detect when a
SUDC case is, in fact, homicide.

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3 It has already been established that for those SUDC cases that are *in fact*
4 homicides but have not been identified as such, the resources deployed are
5 likely to be far fewer, and consequently the depth of the investigation is
6 likely to be far lower, than as would be the case if an adult sudden death
7 was identified as suspicious from the outset. This might seem an obvious
8 statement but the significant factor is that it is far harder to kill an adult
9 without leaving some fairly clear clues that a crime has taken place, so
10 most adult homicides are identified as such from the outset and the
11 necessary resources are then deployed, usually from a Force Major Crime
12 Team. By contrast, as pointed out above, it is entirely possible to kill a small
13 child yet leave few, if any, clues. For this reason the early investigation of
14 a SUDC really needs to be well resourced and well managed. As Marshall
15 (2012, p.32) points out, "*an incorrect [initial] assessment may lead to*
16 *essential evidence being lost and justice denied for the parties affected*".
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29 The challenge for the police therefore is to deploy sufficient resources and
30 carry out sufficient investigative activity, in order to ensure that murders
31 are not missed. Equally challenging is the fact that CAIU officers
32 investigating a SUDC are expected to do their work with sensitivity and
33 discretion to avoid stigmatising innocent families (ACPO, 2014, p.6).
34 Because no serious crime has been identified, there are fewer legal powers
35 available to them to access potential evidence. For example, they would be
36 unable to obtain an authority under the Regulation of Investigatory Powers
37 Act 2000 to examine telephone call data, and they would be unable to
38 obtain a search warrant under the Police and Criminal Evidence Act 2004
39 to search the victim's home and seize evidence. This is not to say that the
40 home would not be visited, but to do so in a SUDC case would have to be
41 with the agreement of the child's parents at a time of their choosing which,
42 if they had actually killed their child, is clearly problematic. Although the
43 College of Policing Child Death Investigation Guidance (ACPO, 2014, p.1)
44 suggests that, "*Even when there are no apparent suspicious factors, the*
45 *police contribution to the investigation must be detailed and thorough*", the
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3 evidence reported thus far is that CAIU Lead Investigators may not have
4 sufficient resources to carry out all the investigative work necessary.
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7 Furthermore, in respect of their training, it is unlikely that CAIU officers will
8 be equipped with the same knowledge and theoretical grounding as their
9 colleagues from MCT, and this will be briefly examined.
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13 The Senior Investigating Officers Development Programme (SIODP) is the
14 current programme provided by the College of Policing which allows senior
15 homicide investigators to become accredited at what is known in policing
16 circles as PIP Level 3. Although a CAIU Detective Inspector may, by chance,
17 have undertaken this training and be accredited at PIP Level 3, it is not a
18 requirement. The CAIU respondents in this, albeit small, study confirmed
19 that none had received PIP Level 3 training.
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26 Having established that those working on a SUDC may have fewer
27 resources and less than optimum training to help them identify whether a
28 SUDC is in fact a homicide, it will be useful to establish exactly what the
29 potential investigative steps might be in straightforward domestic homicide
30 cases.
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36 It may be useful to first briefly look more generally at some expected
37 elements of any police homicide investigation. Neyroud and Disley (2007,
38 p.552) pointed out, that since the review into the flawed Yorkshire Ripper
39 enquiry (Byford, 1981) there has been a drive to "*standardise the way*
40 *major crime investigations are managed*". The vehicles which have been
41 used to try and achieve that standardisation include the set of documents
42 known collectively as College of Policing Authorised Professional Practice
43 (APP), and in particular the *Murder Investigation Manual* (ACPO, 2006) and
44 the *Major Incident Room Standardised Administrative Procedures* (MIRSAP)
45 (ACPO, 2005). The former document gives tactical advice and suggested
46 investigative techniques and the latter document provides a bureaucratic
47 system for setting up a major enquiry and dealing with the enormous
48 amount of information which a murder enquiry can generate.
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To gather some empirical data on this topic, two focus groups were created, each consisting of 5 senior detectives, none of whom were the main respondents for the study. These 10 officers were not interviewed, but were simply asked to create a flipchart which would indicate what investigative activity they would expect to carry out if they were asked to investigate a child death case which, from the outset, was believed to be suspicious – in other words where there were clear criminally inflicted injuries. The following table, *Figure 2* is a representation of the result of their consideration.

RESOURCES	EARLY INVESTIGATIVE ACTIVITY
SIO (DCI)	Forensic recovery - Suspect(s)
Deputy SIO (DI)	Secure death scene and full forensic search
Office manager	Secure victim as a scene
Case Officer (DS)	Arrange forensic post-mortem
Indexers for HOLMES IT System	Interviews with suspects
Analyst	Capture passive data (CCTV, ANPR etc.)
Crime Scene Manager	Seize electronic devices, digital media, phones
Intelligence Manager	House to House strategy
Family Liaison Officer	Full intelligence checks on suspect(s)
Search Advisor (POLSA)	Identify and interview witnesses
Interview Advisor	Community Impact Assessment
Outside Enquiry Team (DS plus 8 DCs)	Media strategy

Figure 2. Response from focus groups

Childhood death investigative deficit

Homicide investigation is considered to be at the pinnacle of police work and the process by which it is carried out is highly systemised, methodical, and involves the coordination of a lot of people from different disciplines. By contrast, the initial investigation of a SUDC which, as indicated by Marshall (2012), may be the one chance to establish if it is in fact a homicide will, as the current research reveals, likely be led by a Detective Inspector or a Detective Sergeant from a Child Abuse Investigation Unit, who has not been trained to PIP Level 3 standard, and who will typically have no more than 2 or 3 investigators working with them. When comparing this evidence with the table at figure 2 it seems clear that there

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3 is a huge disparity in terms of numbers of officers working on the case, and
4 consequently with the amount of investigative activity that can reasonably
5 be carried out.
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9 As an example of how damaging this lack of resourcing can be, not only in
10 respect of surviving or future siblings within the family, but also to the
11 reputation of the force concerned and its investigators, the Independent
12 Police Complaints Commission (IPCC – now known as IOPC) Report into the
13 flawed investigation after the SUDC involving 1 year old Poppi Worthington
14 (IPCC, 2014) concluded that the Detective Inspector from the CAIU who
15 was initially in charge of the investigation failed to attend the scene, offered
16 no direction of scene management, and failed to secure important
17 evidence. However, it is also clear from reading the Report that, "*...she had
18 not been trained as an SIO and she had only attended a detective inspector
19 course many years previous*" (IPCC, 2014, p.25). Neither had she been
20 provided with any specialist training in child death investigation (IPCC,
21 2014. P26). It is also clear from the IPCC Report that this Detective
22 Inspector had no 'team' as such, and in the vital 'Golden Hour' period (Cook
23 and Tattersall, 2010) of this complex enquiry she was attempting to
24 investigate with just 2 uniformed officers who had been earlier deployed by
25 the Force Control Room. The 'Golden Hour' is defined as, "*...the principle
26 that effective early action can result in the recovery of significant material
27 which might otherwise be lost to the enquiry forever*" (ACPO, 2006, p.42).
28 After his Inquest into Poppi's death, the Coroner wrote in his findings,
29 "*There were numerous errors and failings in the first investigation ... it is
30 relevant to note that many pieces of potentially relevant evidence were not
31 gathered or obtained*" (Roberts, 2018, p3.4).
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35 The initial investigation into the Poppi Worthington death was therefore
36 considered by the Coroner and the IPCC to be inadequate and the Detective
37 Inspector in charge of the initial enquiry did not have sufficient experience
38 training or resources, but the evidence provided by Respondents in the
39 current research indicates that the experience of this Detective Inspector
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3 is not unique. One of the Respondents who worked in the CAIU expressed
4 the view that they are still trying to conduct their SUDC investigations with
5 insufficient resources, and this means that the quality of the work
6 conducted, and the lines of enquiry fulfilled are both compromised. The
7 Respondent gave a case example to illustrate that important evidence
8 which might confirm homicide can be lost:
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15 *"There was a case that happened in [my area] of a child who collapsed*
16 *in co-sleeping circumstances. A child was asleep on dad's chest. Dad*
17 *allegedly falls asleep on the sofa watching a film, wakes up, child is*
18 *not alive. We conducted our usual investigation just me and a DS. We*
19 *found no cause for concern but we could only do a cursory scene*
20 *examination, all of it being under no powers. I don't believe there was*
21 *any forensic input into that process. So that was the response to it.*
22 *Anyway, 2 or 3 days later the CT scan comes back - query bleed on*
23 *the brain and retinal haemorrhaging, and there were clear fractures in*
24 *the ribs some of which radiologists were saying were suggestive of NAI*
25 *[non-accidental injury]. So 3 days down the line, having not protected*
26 *your scene, not done any kind of really intrusive inquiries that you*
27 *would do on a major crime investigation around movements,*
28 *behaviours, and all the rest of it, you suddenly are playing catch up*
29 *with a murder investigation. So a bit of a mess that did not resolve in*
30 *any prosecution and in the end we don't really know whether that child*
31 *was murdered"* (MC3).
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46 It is suggested here that there is an investigative deficit between a SUDC
47 investigation and an identified child (or adult) homicide investigation
48 because the SUDC investigation falls into a gap of uncertainty. It might be
49 a homicide, but it probably isn't and, put simply, the Major Crime Teams
50 may only investigate *known* homicide cases, yet sometimes the CAIU
51 investigators have neither the resources nor training to adequately conduct
52 a thorough enough investigation which may identify that it is, in fact,
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3 homicide. Hence, some child homicides forever remain unrecognised as
4 such.
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7 This point of view is supported by one of the Forensic Pathologists (FP2)
8 contributing to the study. They explained that the pathological findings in
9 child death cases, particularly in respect of shaking injuries to a baby, are
10 often challenged vigorously in criminal courts which makes pathologists
11 very wary about giving an early opinion, even when they may be fairly sure
12 that homicide is confirmed. This Respondent also put forward the argument
13 that in many child death cases the only way to demonstrate that the death
14 is probably natural is to confirm the *absence* of injury, and that the only
15 way to do that is a thorough and open minded autopsy where one looks for
16 injury. This may seem patently obvious, but the point may equally apply to
17 the police investigation. If the *absence* of crime is not confirmed through a
18 thorough and well-resourced investigation, the possibility that the child has
19 been murdered remains.
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23 From the evidence gathered during the current study it has thus far been
24 possible to draw an inference that in some SUDC cases CAIU investigators
25 may not have the training or resources available to adequately rule out
26 homicide or confirm it. It is also possible to draw an inference that MCTs
27 have been subject to cuts in staff numbers of up to 30%, yet the number
28 of homicide cases they are expected to deal with has not gone down. The
29 final theme for discussion therefore is whether, even in cases where the
30 CAIU investigator *has* a suspicion that the case is homicide, the MCT will
31 take the case over and run a properly resourced enquiry as indicated in
32 *Figure 2*.
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35 ***The transfer to MCT in suspicious cases***

36
37 Evidence from the current respondents indicated that there are variations
38 as to when a force or regional MCT may take over a child death case. In
39 one area every SUDC is 'overseen' by a trained MCT SIO. Under this model,
40 although they will not act as the Lead Investigator or provide resources,
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3 they do at least keep a 'watching brief' on the case and they will act in an
4 advisory capacity to the CAIU Lead Investigator. It was explained by the
5 Respondent (MC3) that this model is possible because the force has
6 structured its investigators in such a way that CAIU and MCT teams all sit
7 within the same wider department under a single Detective Superintendent.
8 In other areas however, there is absolutely no involvement by the Major
9 Crime Team until a homicide has been confirmed. This is evidenced by a
10 Detective Chief Inspector from a Major Crime Team who was asked when,
11 if at all, her team would feel that a child death would come within her team's
12 remit to take it over and she replied:

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22 *"Not until a forensic post mortem had given homicide as the cause of*
23 *death". (MC5)*

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26 This position was broadly confirmed by all CAIU Respondents, for example:

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29 *"Only if clearly manslaughter or murder. Sus death likely to remain*
30 *with CAIU"* (CA3)

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33 *"A suspicious death which isn't confirmed is likely to [remain with*
34 *CAIU] - depends on which SIO we ask!"* (CA2)

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37 When asked if the staffing cuts in MCTs had made them more discerning
38 about which cases they would take on, one Respondent said:

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41 *"Yes. Well it is mixed whether the MIT will take on child homicide if*
42 *that's what you mean. It can depend on the SIO who they speak to.*
43 *Some may take a suspicious child death immediately but as we lose*
44 *more and more staff there is a tendency to push back on jobs until it*
45 *is clear that we are dealing with a murder."* (MC5)

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48 Other MCT Respondents (MC2, MC3) said that in their team the trigger for
49 MCT taking over a case would be if, and when, a Pathologist confirmed
50 homicide.

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53 The flaw in this proposition is that the pathology in a child death is largely
54 a lengthy process of excluding natural causes until homicide is the only
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3 plausible explanation (Krous et al. 2005). It was confirmed by all the
4 pathologists contributing to this study that even where there are initial
5 suspicions, this takes a long time because various histology has to be
6 carried out on tissue and internal organs. When asked how long this process
7 would typically take, a Forensic Pathologist replied:
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13 *"If for example the child dies and a thin bilateral subdural haemorrhage*
14 *is found at PM, this is clearly very suspicious but to prove the retinal*
15 *haemorrhages and examine the fixed brain will require specialist*
16 *ophthalmic pathology and neuropathology, which typically takes*
17 *months to complete. It follows that there may be a delay before the*
18 *job is confirmed as definite homicide. Even if there is ante mortem*
19 *evidence of trauma, specialist ophthalmic pathology and*
20 *neuropathology will still be needed, as well as possibly bone pathology,*
21 *so though it may be pretty clear the child/infant has been assaulted, a*
22 *definitive statement will almost certainly take several months to*
23 *complete."* (FP1)
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34 Another Forensic Pathologist (FP2) who carries out all their own histology
35 rather than sending the organs to an external expert, also confirmed that
36 in child death cases it would often be 5 or 6 months before they were able
37 to provide the police with a firm conclusion that homicide was the cause of
38 death.
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44 It follows then that if the initial police investigation is not properly resourced
45 *until* homicide is identified then clearly, as in the Poppi Worthington case,
46 much physical evidence could be lost, as well as opportunities for forensic
47 recovery at the death scene, passive data recovery, or digital media
48 investigation (see *Figure 2*).
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54 The other rather illogical position with a Major Crime Team not accepting
55 the case until a Forensic Post Mortem has concluded homicide is that for
56 any SUDC to even be subject to a *Forensic Post Mortem* examination there
57 must have been sufficient suspicions to convince a Coroner that this type
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3 of Post Mortem examination is required. According to Peres (2017) a
4 Forensic Post Mortem in England and Wales costs the police £4,000 in an
5 average case, and therefore one is only requested by police when the
6 suspicions of crime are already fairly high. The MCT Respondents in the
7 current study confirmed that it is almost certainly the case that if an adult
8 sudden death was felt to be suspicious enough to warrant a highly
9 expensive Forensic Post Mortem., the force MCT would certainly be running
10 the investigation from the outset, and they would not wait several weeks
11 or months for formal confirmation of homicide before deploying their
12 extensive resources and investigative services.
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16 Finally, there is also evidence from some Respondents in the current
17 research (MC1, MC2, MC3, CA2), that in their Forces it is not even certain
18 that the dedicated Major Crime Team will take over an investigation even
19 when homicide is confirmed. This could be because a long passage of time
20 has elapsed until such confirmation and the CAIU simply keep the enquiry
21 themselves because they have done a lot of the work they believe is
22 required. This, in itself, does not necessarily mean a lower quality of
23 investigation, but clearly in Forces where that practice exists, they have
24 created a two-tier system of homicide investigation, one for adults and one
25 for children.
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28 **Conclusion and implications for Police policy makers**

29
30 Most infants who die suddenly and unexpectedly, die because of natural
31 causes. In older children, where SIDS is not a factor, it is likely that any
32 natural disease or genetic condition will be detected by medical science.
33 However, unlike the killing of an adult it is disturbingly possible to kill a
34 child and leave few, if any, physical clues on the body. The overall
35 investigation therefore has to be of high quality to identify any clues that
36 have been left by the perpetrator at the scene or in other ways. Pathology
37 alone will not necessarily be able to confirm homicide and therefore the
38 medical input needs to be complemented by a thorough and searching
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3 police investigation, albeit an investigation sensitive to the probability that
4 the carers are in fact innocent.
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7 It could be argued that the 'investigative deficit' in SUDC is no greater than
8 with any adult sudden death investigation, but this paper takes the position
9 that child death cases are different for three key reasons: children are not
10 meant to die, the greater timescale to reach a conclusive medical
11 determination, and the vulnerability of any current or future siblings. Child
12 death cases often present complex medical evidence and because the
13 pathological findings may be controversial when aired in court, pathologists
14 are often extra careful to ensure supporting findings from experts such as
15 neuropathologists before confirming their conclusions. Because the
16 complex pathology in child death can take several months to provide a
17 definitive answer, some actual (but not yet clearly identified) child homicide
18 cases are being managed by a very small team who are untrained in major
19 crime investigation. Crucially, if there are other children within the
20 household, they could be at risk for many months if left with a carer who is
21 in fact a murderer.
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35 It is evident that cuts to police service budgets since 2010 have affected all
36 elements of policing, including homicide investigation. As a result many
37 police force MCTs have seen reductions in personnel of up to one third,
38 making it more likely that their demarcation lines for deciding which type
39 of cases they take on are drawn tighter and become less flexible. Because
40 SUDC investigations rarely offer certainty in the initial stages, in other
41 words the early signs are often not clear enough to determine homicide,
42 some MCT decision makers feel it is not within their remit to investigate,
43 even perhaps where there are enough suspicions to justify a costly Forensic
44 Post Mortem. Sometimes, the only way to identify whether or not a SUDC
45 is a homicide is for extensive and robust enquiries to be undertaken, but
46 the fact that the enquiry is conducted by an under resourced and less than
47 optimally trained team may mean that evidence remains undiscovered and
48 homicide is never detected.
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3 Even CAIU DIs who have clear suspicions about their SUDI case are
4 sometimes experiencing "push-back" from MCTs, or in some cases the MCT
5 will only provide some limited supplementary assistance whilst the case is
6 retained by a DI from CAIU. Respondents agree that with far fewer
7 resources than an MCT would routinely deploy for a clear straightforward
8 adult homicide, it is likely that in SUDC investigations some important early
9 lines of enquiry and actions are not being completed which can mean that
10 actual homicide is not determined at all, or that the case is weaker when
11 presented to the CPS for a charging decision. This paper does not suggest
12 that every MCT has the same policy, but there is enough evidence from the
13 current research to draw an inference that unlike an adult death, some
14 MCTs will not take on a suspicious child death until and unless there is
15 conclusive evidence that homicide is the cause. Normally, however, this
16 can only be determined by a post mortem process which takes several
17 months, so consequently the 'Golden Hours' are compromised due to a lack
18 of robust investigation.
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33 Police policy makers and senior leadership teams need to recognise the
34 investigative deficit in SUDC investigation. The rhetoric from some Police
35 and Crime Commissioners (e.g. PCC Hampshire, 2017) is that despite any
36 budget cuts their number one priority is protecting the vulnerable from
37 harm. If a person in England and Wales is destined to become a victim of
38 homicide there is evidence that it is four times more likely to happen in
39 their first year than at any other age (Brookman and Maguire 2005, p.21).
40 This makes infants by far the most vulnerable people in society, yet the
41 apparently less than adequate police investigation into some SUDCs may
42 leave the living or unborn siblings of child homicide victims at risk.
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52 It may be impractical and in some ways undesirable for the Major Crime
53 Teams to take on the full investigation of all SUDC - indeed most of them
54 are not crimes – however, the approach described above, whereby a
55 trained MCT SIO at least maintains a 'watching brief' over every SUDC
56 investigation may at least lessen the chances that a child homicide could
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3 remain unrecognised as such. The College of Policing Guidance (ACPO,
4 2014 p13) states, "Even when there are no apparent suspicions, as a
5 minimum it is suggested that a team of three investigators will be required
6 to assess and manage scenes, carry out interviews and follow lines of
7 enquiry." The present study has indicated that this guidance is not always
8 being adhered to, and that even this modestly sized team is not available
9 to some CAIU senior detectives investigating a SUDC. If an SIO has
10 oversight of the case and has some level of accountability for its success,
11 then at least the minimum level of resourcing might, in more cases, be
12 deployed as a matter of routine.
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22 In respect of training, the College of Policing (ACPO, 2014 p13) suggests
23 that any officer deployed to investigate a SUDC should have undertaken
24 the Investigation of Sudden Childhood Death Course. It is outside the scope
25 of this study to determine whether all police forces in England and Wales
26 are providing this training to officers, but certainly the evidence from the
27 Poppi Worthington case would indicate that they are not. It may therefore
28 be useful for the College of Policing to fund, or conduct further more
29 detailed research to establish whether their own recommended training
30 programme is available to all officers, and to consider further whether as
31 with the PIP Level 3 system for SIOs, there should be some form of
32 advanced accreditation for CAIU investigators who are expected to manage
33 these difficult and complex investigations.
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